

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/01/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN CITY CARE & REHABILITATION C		STREET ADDRESS, CITY, STATE, ZIP CODE 919 MEDICAL PARK DRIVE MOUNTAIN CITY, TN 37683		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual licensure survey at Mountain City Care and Rehabilitation Center, conducted on April 29-May 1, 2013, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

Diana Branch
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
5-16-13

STATE FORM

5599

UQGO11

If continuation sheet 1 of 1

MAY 17 2013